STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00130877. Complaint IN00130877-Substantiated, Federal/State Deficiencies related to the allegations are cited at F-240 and F279. Unrelated deficiency is cited. . Survey Dates: June 26 & 27, 2013 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Survey team: Angela Strass, RN Census bed type: SNF: 4 SNF/NF: 72 Total: 76 Census payor type: Medicare: 14 Medicaid: 52	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 10 Total: 76 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 28, 2013 by Randy Fry RN.			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to report misappropriation of resident property to local law enforcement for 1 of 3 resident records reviewed and failed to ensure the facility policy was accurate as directed by the Center for Medicare and Medicaid Services. Finding includes: On 6/26/13 at 7:30 a.m. interview with resident (A) indicated she had $80.00 missing from her room. The resident indicated she had put the money in a little coin purse in her purse and had put it in her drawer. The resident indicated the facility was not going to replace her missing money. On 6/26/13 at 8:05 a.m. the Director of Nursing (DON) was queried about the residents missing money. The DON indicated resident (A) had in the	F000226	I. It is the policy and procedure of University Park to report all occurances related to F- tags 224,225,226 to all Regulatory agencies, and local law enforcement, A. Resident A's occurance and allegation of missing money was reported to the local law enforcement agency, and other regulatory agencies.II. No other residents were affected, as evidenced by the investigation tools of interviews of residents and staff. (see attachment#1)III. The investigation management tool has been updated to reflect the tab for the local law enforcement notification. (see attachment #2).IV. The tools will be used in the event of any allegation, to ensure compliance of reporting appropriately. These will be brought to the monthly QMP meetings to ensure 100% compliance is achieved and reviewed by the committee, for 6 months.V. 7/25/13	07/25/2013

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	past stated she had missing money and they had replaced it but not this time. Further interview indicated the facility had investigated the missing money and reported the incident to the State Department of Health, Ombudsman and Adult Protective Services. On 6/26/13 at 8:40 a.m. the Administrator and DON were queried if they had reported the missing money to the police and they indicated they had not. At 10:00 a.m. on 6/26/13 the Administrator presented the writer with a piece of paper with a report number written on it and indicated she had reported the incident of the missing money for resident (A) to the local police department. Interview with the Administrator indicated she did not know she was to report to the police, and had followed the facility policy. On 6/27/13 at 11:30 a.m. the facility administrator presented the facility policy "Abuse Prevention, Intervention, Investigation & Crime Reporting Policy", which had a revision date of December 2012.			

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	Review of the facility policy on 6/27/13 at 11:45 a.m. indicated the following: "Regulations require employees that provide services to elderly persons or dependant adults (mandated reporters) to report instances of suspected or allegations of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection." On 6/27/13 at 12:40 p.m. the Administrator and DON were informed of a Directive by CMS (Center for Medicare and Medicaid Services) dated 6/17/11 and revised on 8/12/11 which indicated reports of suspicion of a crime must be submitted to at least one law enforcement agency of jurisdiction and the State Agency. 3.1-28(a)			

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F000240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Based on record review and interview the facility failed to ensure personal care products were available for 2 of 13 residents interviewed. Finding includes: On 6/26/13 from 5:15 a.m. through 6:15 a.m. observation indicated there were 8 nursing staff members working. The 8 employees were interviewed related to the availability of incontinence pads and briefs for the residents. 7 of the 8 staff members indicated they would run out of incontinence products and would have to borrow from other residents to provide for some of the residents who did not have products available. The staff indicated they did not have access to the supply room to get more if needed and would borrow from other residents. During the interviews staff indicated there were times when they had to use the	F000240	I. It is the policy and procedure of University Park to provide care in a manner to enhance the residents lives.A. Resident A's care plan updated to reflect her current status and behaviors of use of the incontinence products, B. her usage and size of incontenance products were re-evaluated for appropriateness. II. No other residents were affected, a audit of other residents who use incontenance products, completed, (see attachment #3) to ensure that they are recieveing the products daily.III. A emergency supply of incontenance products will be kept in the Nurses med room for immediate access to staff, B. Staff assigned to Central Supply will pass all personal supplies on a daily basis in the AM to ensure continuity of supplies.Evaluation of resident needs and use of products will be reviewed.IV. Don/Designee will do weekly random audits, to ensure that the supplies are being passed and that continuity of supplies is maintained.These will be brought to monthly QMP meetings for review by the committee, for 6 months.V. 7/25/13	07/25/2013

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	wrong size briefs on residents due to residents not having briefs in their rooms. On 6/26/13 at 7:50 a.m interview with resident (A) indicated she used urinary incontinence pads but often ran out of those pads. During further interview with the resident she state she would use towels in place of the pads. The resident stated the facility staff only give her 3 pads at a time. The resident indicated she currently was using a towel, and showed the writer that she keeps her pads in her top dresser drawer and there were no pads available. On 6/26/13 at 8:00 a.m. the Director of Nursing (DON) was asked to come to the resident's room and speak to her about the issue. The DON entered the room and observed the resident in the bathroom with the towel she had been using. The DON searched the resident's room and was unable to find any incontinence pads in the resident's room. Staff were then directed to get the resident pads.			

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	On 6/26/13 at 8:35 a.m. interview with employee #11 indicated she worked in Central Supply and was directed to pass out incontinence products daily. She provided a list of residents with the amount of pads they were to have daily. Review of the record indicated resident (A) was to be provided 3 pads daily. Interview with the DON on 6/27/13 at 12:00 p.m. indicated resident (A) was able to toilet herself and was constantly changing her incontinence pads. "We continually give her pads. I could give her 40 pads and she would go through them." The DON was queried about the list of the number of pads residents were to be given daily, and she indicated the residents on the list who were to get 3 pads daily were usually continent throughout the day. On 6/26/13 at 9:00 a.m. review of the "List" provided by employee #11 indicated 48 residents were on the list. At the bottom of the page, highlighted in yellow was written "These residents only get 3 per day."			

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	There were 28 residents highlighted who were to get 3 pads or briefs per day. Interview with resident (D) on 6/27/13 at 12:15 p.m. indicated last week the facility ran out of briefs for her. The resident stated she was unable to get up and out of bed that morning for 4 hours until the facility was able to obtain the briefs. The resident indicated she needed large briefs and the facility did not have any on that morning. This federal tag relates to complaint IN00130877 3.1-32(a)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to implement a behavior plan of care for 1 resident (A) in a sample of 3 resident records reviewed. Finding includes: On 6/26/13 at 7:50 a.m interview with resident (A) indicated she used urinary incontinence pads but often ran out of those pads. During further interview with the resident she state she would use towels in place of the pads. The resident stated the facility staff only give her 3 pads at a time. The resident indicated she currently was using a towel, and showed the writer that she keeps her pads in her top dresser drawer and there were no pads available.	F000279	I. It is the policy and procedure of University Park to develope and implement care palns specific to each residents needs. Resident A's care plans were reviewed and updated to reflect her current behaviors.II. There were no other residents affected, A audit of resident care plans (who are on behavior management program) was done to ensure that they currently relfect the residents who have behaviors. (see attachments #4)III. DON/Designee will review careplans in the monthly Behavior management meetings, to ensure that they reflect the current	07/25/2013

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	On 6/26/13 at 8:00 a.m. the Director of Nursing (DON) was asked to come to the resident's room and speak to her about the issue. The DON entered the room and observed the resident in the bathroom with the towel she had been using. The DON searched the resident's room and was unable to find any incontinence pads in the resident's room. Staff were then directed to get the resident pads. Interview with the DON on 6/27/13 at 12:00 p.m. indicated resident (A) was able to toilet herself and was constantly changing her incontinence pads. "We continually give her pads. I could give her 40 pads and she would go through them." Further interview with the DON indicated the issue with resident (A)using so many incontinence pads was a behavior. The DON was further queried about a plan of care to address the behavior, and she indicated they did not have a plan to address the behavior. 3.1-35(a)		behaviors of residents on the behavior management care plans.IV. The behavior management meetings notes will be brought the the QMP meetigns monthly for review by committee for 6 months.V. 7/25/13	